United States Department of Labor
Employees' Compensation Appeals Board

R.L., Appellant	)	
and	)	**Docket No. 20-1069**
	)	**Issued: April 7, 2021**
DEPARTMENT OF AGRICULTURE, FARM SERVICE AGENCY, St. Louis, MO, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On April 20, 2020 appellant, through counsel, filed a timely appeal from an April 3, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish greater than six percent permanent impairment of the right arm and three percent of the left arm for which she previously received schedule award compensation.

FACTUAL HISTORY

On November 3, 2008 appellant, then a 49-year-old systems analyst, filed an occupational disease claim (Form CA-2) alleging that due to factors of her federal employment she developed bilateral carpal tunnel syndrome and a ganglion cyst on the right wrist as a result of performing computer work. She became aware of her condition and realized that it was caused or aggravated by her federal employment on October 22, 2008. OWCP accepted the claim, assigned OWCP File No. xxxxxx081 for bilateral carpal tunnel syndrome. Appellant did not immediately stop work.

Appellant had previously filed a traumatic injury claim (Form CA-1) for an injury sustained on June 1, 2006 when her foot got stuck in mud and caused her to fall, OWCP File No. xxxxxx958. OWCP accepted that claim for right ankle sprain and sprain of the left lateral collateral ligament of the knee.[3]

On August 28, 2006 appellant fell on uneven pavement and sprained her wrist and reinjured her right ankle, OWCP File No. xxxxxx274. OWCP accepted the claim for sprain of the right ankle calcaneofibular ligament and right wrist sprain. On August 12, 2008 it granted appellant a schedule award for four percent permanent impairment of the right upper extremity and zero percent permanent impairment for the right lower extremity. The period of the award was from October 2 through December 28, 2006.

Under OWCP File No. xxxxxx081 appellant underwent a magnetic resonance imaging (MRI) scan of the right wrist on October 16, 2008 which revealed an intact triangular fibrocartilage complex (TFCC) intrinsic wrist ligament, intact extrinsic wrist ligaments, carpal tunnel and guyon canal, normal median and ulnar nerves, moderate tendinopathy of the extensor carpi ulnaris tendon with a partial split tear of the tendon at the level of the ulnar styloid, mild synovitis of the radiocarpal and intercarpal joints, focal dorsal synovitis in the midcarpal compartment, and no evidence of a ganglion cyst. Electromyogram (EMG) and nerve conduction velocity (NCV) tests were normal.

On March 2, 2010 appellant filed a claim for a schedule award (Form CA-7) for bilateral carpal tunnel syndrome under OWCP File No. xxxxxx081. By decision dated April 1, 2010, OWCP granted her a schedule award for three percent permanent impairment of the left upper extremity. The period of the award ran from June 22 to August 26, 2009.

[3] On October 2, 2007 OWCP granted appellant a schedule award for seven percent permanent impairment of the right lower extremity and zero percent of the left lower extremity. The period of the award was from October 31, 2006 through March 21, 2007. On October 17, 2019 OWCP granted appellant an additional schedule award of 19 percent permanent impairment of the right leg and 2 percent permanent impairment of the left leg for a total of 26 percent permanent impairment of the right lower extremity and 2 percent of the left lower extremity. The period of the award was from June 20, 2019 through August 16, 2020.

On September 27, 2010 appellant requested reconsideration.

By decision dated October 25, 2010, OWCP denied appellant's request for reconsideration of the merits of her claim under 5 U.S.C. § 8128(a).

On October 14, 2010 appellant filed a Form CA-1 claim after falling on broken pavement in the parking lot on her way to lunch on October 4, 2010. OWCP assigned that claim OWCP File No. xxxxxx778 and accepted it for right ankle sprain, left knee contusion, right wrist sprain, right shoulder sprain, and left elbow contusion. On July 2, 2012 it denied appellant's claim for an additional schedule award.

On June 30, 2016 appellant filed a Form CA-2 alleging that she developed de Quervain's tenosynovitis as a result of repetitive computer key entry. OWCP assigned that claim OWCP File No. xxxxxx089 and accepted it for right wrist radial styloid tenosynovitis (de Quervain's). On June 15, 2016 appellant underwent an MRI scan of the right wrist, which revealed mild subluxation distal radial ulnar joint with adjacent soft tissue edema, probable peripheral tear of the TFCC with what appeared to be an intact radial attachment, and mild partial tear of the extensor carpi ulnaris tendon without full-thickness tear or retraction. By decision dated January 22, 2019, OWCP denied her claim for an additional schedule award.

Appellant filed a Form CA-2 on July 6, 2016 for her elbow pain, which she indicated radiated constantly from repetitive motion while working. She noted that she first became aware of her condition and its relationship to her federal employment on June 22, 2016. OWCP assigned that claim OWCP File No. xxxxxx592 and accepted it for right elbow lateral epicondylitis. On July 15, 2016 an MRI scan of the right elbow revealed minimal lateral epicondylitis without full-thickness tear or retraction and a normal medial epicondyle. On August 27, 2019 OWCP granted appellant a schedule award for one percent impairment of the right arm. The period of the award ran from July 29 through August 19, 2019.

OWCP administratively combined OWCP File Nos. xxxxxx958, xxxxxx274, xxxxxx081, xxxxxx778, xxxxxx592, and xxxxxx089, with OWCP File No.xxxxxx958 designated as the master file.

Under OWCP File No. xxxxxx081, OWCP received a June 20, 2019 report from Dr. Neil Allen, a Board-certified internist and neurologist.[4] Dr. Allen reviewed medical records, electrodiagnostic test results, and opined that appellant attained maximum medical improvement (MMI). He provided an impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] Dr. Allen related appellant's account-of-moderate interference with communication and physical activity, severe interference with nonspecialized hand activities, and mild interference with sleep. He administered a *Quick*DASH questionnaire, which yielded a score of 48. On examination of

[4] On June 2, 2014 appellant filed a notice of recurrence (Form CA-2a) beginning May 20, 2014 causally related to her accepted employment condition. By decision dated July 7, 2016, OWCP denied her claim for a recurrence of disability beginning May 20, 2016.

[5] A.M.A., *Guides* (6th ed. 2009).

the right wrist, Dr. Allen found no atrophy, a normal sensory examination, joint line and styloid tenderness, and intact strength. He observed 56 degrees, 51 degrees, and 56 degrees of flexion, 42 degrees, 51 degrees, and 49 degrees of extension, 31 degrees, 25 degrees, and 22 degrees of radial deviation, and 50 degrees, 48 degrees, and 39 degrees of ulnar deviation. On examination of the left wrist, Dr. Allen noted no atrophy, a normal sensory examination, and tenderness to palpation through the distal third of the forearm and joint line of the wrist. He observed 56 degrees, 51 degrees, and 60 degrees of flexion, 39 degrees, 48 degrees, and 51 degrees of extension, 24 degrees, 28 degrees, and 25 degrees of radial deviation, and 45 degrees, 48 degrees, and 49 degrees of ulnar deviation. Dr. Allen noted an MRI scan of the right wrist performed on "June 15, 2019."[6] Revealed mild subluxation of the distal radial ulnar joint with adjacent soft tissue edema, probable peripheral tear of the TFCC with an intact radial attachment, and mild partial tear of the extensor carpi ulnaris tendon without full-thickness tear or retraction.

Utilizing the A.M.A., *Guides*, for the right wrist he found that, under the diagnosis-based impairment (DBI) methodology, using Table 15-3, page 396, the most appropriate class of diagnosis (CDX) for rating purposes was a TFCC tear, a documented injury with residual findings, which was a Class 1 with a default value of eight percent. Dr. Allen assigned a grade modifier for functional history (GMFH) of 2 based on a *Quick*DASH score of 48, pain with normal activity, and the ability to perform self-care activities with modification but unassisted. He assigned a grade modifier for physical examination (GMPE) of 1, noting mild palpatory findings consistently documented without observed abnormalities. Dr. Allen found that the grade modifier for clinical studies (GMCS) was not considered in the adjustment because it was used in class placement. He utilized the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (2 - 1) + (1 - 1) = +1, which resulted in a grade C or nine percent permanent impairment of the upper right extremity due to appellant's TFCC tear.

With regard to the left wrist impairment Dr. Allen determined that the range of motion (ROM) method resulted in a higher impairment rating than that calculated using the DBI method.[7] Using Table 15-32, page 473, he noted 60 degrees of flexion for zero impairment, 50 degrees of extension for three percent impairment, 50 degrees of ulnar deviation for zero impairment, and 30 degrees of radial deviation for zero impairment. Dr. Allen calculated three percent left upper extremity impairment based on the ROM method. He applied the net adjustment formula and found a grade 1 modifier for ROM, a GMFH of 2. Using Table 15-36, page 477, Dr. Allen calculated three percent upper extremity impairment.[8] Dr. Allen indicated that the EMG and NCV testing did not reveal evidence of carpal tunnel syndrome and therefore the impairment rating could not be based on a diagnosis of carpal tunnel syndrome.[9]

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[6] This appears to be a typographical error as the record indicates that appellant underwent a right wrist MRI scan on June 15, 2016.

[7] Under the DBI method Dr. Allen rated appellant using the diagnosis of wrist pain, which had a default rating of one percent pursuant to Table 15-3, page 395 of the A.M.A., *Guides.*

[8] The calculation is as follows: 3 percent upper extremity impairment x 5 percent + 3 (grade modifiers) = 3.15 percent impairment rounded to the nearest whole number. *See* Table 15-36, page 477 of the A.M.A., *Guides.*

[9] A.M.A., *Guides* 448.

On August 12, 2019 appellant filed a claim for an additional schedule award (Form CA-7).

In a development letter dated August 16, 2019, OWCP requested that appellant submit an impairment rating in accordance with the A.M.A., *Guides*.

On September 18, 2019 OWCP referred appellant's case to a district medical adviser (DMA) to determine whether the medical evidence of record established permanent impairment of a scheduled member or function of the body causally related to her accepted conditions.

On November 7, 2019 Dr. Herbert White, Jr., a Board-certified orthopedic surgeon serving as the DMA, reviewed the medical evidence of record[10] and determined that appellant reached MMI on June 20, 2019, the date of Dr. Allen's examination. He concurred with Dr. Allen's opinion that the Entrapment/Compressive Neuropathy Grid of the A.M.A., *Guides* could not be used to rate impairment as the EMG and NCV studies were normal. However, the DMA disagreed with Dr. Allen's rating based on the TFCC tear. He noted that Dr. Allen cited to an MRI scan dated "June 15, 2019"[11] Which indicated a "probable TFCC tear", not a definite TFCC tear. The DMA further stated "I did not have that study to review," but further indicated that a definite TFCC tear diagnosis was required to rate the impairment using this diagnosis. He noted a split tear on the MRI scan and used the diagnosis of laceration or ruptured tendon to rate impairment.

Utilizing the A.M.A., *Guides*, the DMA found that, under the DBI methodology, appellant had laceration or ruptured tendon injury under Table 15-3, page 395, residual loss of function with normal motion, which was a Class 1 with a default value of five percent. He applied a GMFH of 2 based on a *Quick*DASH score of 48 and a GMPE of 1, noting mild tenderness and motion deficits. The DMA found that the GMCS was excluded as it was used in class placement. He applied the net adjustment formula (GMFH - CDX) + (GMPE - CDX) = (2 - 1) + (1 - 1) = +1, and found six percent permanent impairment of the right upper extremity due to laceration or ruptured tendon. The DMA calculated right upper extremity impairment using the ROM method, which yielded three percent upper extremity impairment pursuant to Table 15-32, page 473 of the A.M.A., *Guides*.[12] He further indicated that if the A.M.A., *Guides* provide more than one method to rate a particular impairment or condition the method producing the higher rating must be used. In this case the DBI method resulted in greater impairment.

With regard to the left wrist impairment, the DMA used the DBI method for non-specific wrist pain, Table 15-3, page 395 of the A.M.A., *Guides* and found a Class 1 with a default value of one percent. He noted GMFH of 2, GMPE of 1, and indicated that clinical studies were excluded. Using the net adjustment formula, the DMA calculated one percent impairment of the left upper extremity under the DBI method. He calculated appellant's left upper extremity

[10] DMA Dr. White noted that he reviewed the following diagnostic studies: an MRI scan of the right wrist dated October 16, 2008 and NCV studies dated October 17, 2008.

[11] *See supra* note 10.

[12] Using Table 15-32 of the A.M.A., *Guides*, page 473, the DMA noted 60 degrees of flexion for zero impairment, 50 degrees of extension for 3 percent impairment, 50 degrees of ulnar deviation for zero impairment, and 30 degrees of radial deviation for zero impairment.

impairment using the ROM method finding three percent upper extremity impairment pursuant to Table 15-32, page 473 of the A.M.A., *Guides*.

By decision dated January 13, 2020, OWCP granted appellant a schedule award for an additional two percent permanent impairment of the right arm and zero percent permanent impairment of the left arm. The period of the award ran from June 20 through August 2, 2019. OWCP afforded the weight of the medical evidence to the DMA's November 7, 2019 report. It noted that appellant was previously awarded four percent impairment of the right arm on August 12, 2008 under OWCP File No. xxxxxx274 and would therefore be entitled to an additional two percent impairment. With regard to the left arm, appellant was previously awarded three percent impairment on March 19, 2010 under OWCP File No. xxxxxx081 and was not due an additional award.

On February 8, 2017 Dr. Shawn Kutnik, a Board-certified orthopedist, reviewed an MRI scan of the right wrist which was consistent with a TFCC tear. He diagnosed sprain of the radiocarpal joint of the right wrist, initial encounter, right wrist extensor carpi ulnaris tendinitis, and TFCC tear. Dr. Kutnik opined that the examination was consistent with extensor carpi ulnaris tendinitis though some element of TFCC tear may be in place. He recommended a cortisone injection, which appellant declined. In a May 17, 2017 report, Dr. Kutnik treated appellant in follow-up and diagnosed extensor carpi ulnaris tendinitis and TFCC tear. He noted that although there were residual symptoms she was doing well and was not interested in surgical intervention. Dr. Kutnik noted that appellant was at MMI with no restrictions to the right arm.

Appellant underwent physical therapy treatment from February 28 through April 13, 2017.

On February 10, 2020 appellant, through counsel, requested reconsideration. Counsel asserted that the DMA did not accept the finding that appellant sustained a TFCC tear and therefore he did not rate her for this diagnosis. He indicated that the file documents that she had a TFCC tear of the right wrist, citing to an MRI scan report and notes from Dr. Kutnik.

By decision dated April 3, 2020, OWCP denied modification of the January 13, 2020 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,[13] and its implementing federal regulations, set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified

[13] *Supra* note 2.

edition of the A.M.A., *Guides*, published in 2009.[14] The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[15]

It is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of an employment injury.[16] OWCP's procedures provide that, to support a schedule award, the file must contain competent medical evidence which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred, describes the impairment in sufficient detail so that it can be visualized on review, and computes the percentage of impairment in accordance with the A.M.A., *Guides.*[17]

In addressing upper extremity impairments, the sixth edition requires identification of the impairment CDX, which is then adjusted by grade modifiers based on GMFH, GMPE, and GMCS.[18] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[19]

The A.M.A., *Guides* also provide that the ROM impairment methodology is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other DBI sections are applicable.[20] If ROM is used as a standalone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are measured and added.[21] Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.[22]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[23] Regarding the application of

[14] For decisions issued after May 1, 2009 the sixth edition of the A.M.A., *Guides* is used. A.M.A., *Guides* (6th ed. 2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017).

[15] *See K.J.*, Docket No. 19-1492 (issued February 26, 2020); *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

[16] *See T.H.*, Docket No. 19-1066 (issued January 29, 2020); *D.F.*, Docket No. 18-1337 (issued February 11, 2019); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[17] *See* 5 U.S.C. § 8101(19); *J.K.*, Docket Nos. 19-1420 & 19-1422 (issued August 12, 2020); *Francesco C. Veneziani*, 48 ECAB 572 (1997).

[18] A.M.A., *Guides* 383-492.

[19] *Id*. at 411.

[20] *Id*. at 461.

[21] *Id*. at 473.

[22] *Id*. at 474.

[23] FECA Bulletin No. 17-06 (May 8, 2017).

ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides in pertinent part:

> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[24]

The Bulletin further advises:

> "If the rating physician provided an assessment using the ROM method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE."[25]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[26]

ANALYSIS

The Board finds that this case is not in posture for decision.

In his June 20, 2019 report, Dr. Allen opined that appellant had nine percent permanent impairment of the right upper extremity. He reviewed and referenced a June 15, 2016 MRI scan of the right wrist, which revealed mild subluxation of the distal radial ulnar joint with adjacent soft tissue edema, probable peripheral tear of the TFCC with what appeared to be an intact radial attachment, and mild partial tear of the extensor carpi ulnaris tendon without full thickness tear or retraction. Using Table 15-3, page 396, Dr. Allen identified the most appropriate diagnosis for rating purposes was a TFCC tear, a documented injury with residual findings, which was a Class 1 with a default value of eight percent. He noted grade modifiers and applied the net adjustment formula and found nine percent permanent impairment of the upper right extremity due to appellant's TFCC tear. The basis of Dr. Allen's impairment rating was the June 15, 2016 MRI scan of the right wrist.

In accordance with its procedures, OWCP properly referred the evidence of record to a DMA, Dr. White, who, in a November 7, 2019 report, reviewed the medical record and determined that appellant's date of MMI was June 20, 2019, the date of Dr. Allen's impairment examination.

[24] *Id*.

[25] *Id.*; *see also H.H.*, Docket No. 19-1530 (issued June 26, 2020); *A.G.*, Docket No. 18-0329 (issued July 26, 2018).

[26] *Supra* note 17 at Chapter 2.808.6(f); *P.W.*, Docket No. 19-1493 (issued August 12, 2020).

Utilizing the sixth edition of the A.M.A., *Guides*, the DMA found that she had a total of six percent permanent impairment of the right upper extremity under the DBI methodology. He identified the most appropriate diagnosis for rating purposes was a laceration or ruptured tendon. The DMA, however, did not review the June 15, 2016 MRI scan of the right wrist. He noted that he reviewed only October 2008 diagnostic studies. Thus, the Board finds that his report requires clarification.

It is well established that, proceedings under FECA are not adversarial in nature, and while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[27] Once OWCP undertook development of the evidence by referring appellant's case file to an OWCP medical adviser, it had an obligation to do a complete job and obtain a proper evaluation and report that would resolve the issue in this case.[28] The Board will therefore set aside OWCP's April 3, 2020 decision and remand the case for the DMA to conduct a proper analysis under the A.M.A., *Guides* in order to determine if she has greater than six percent permanent impairment of her right upper extremity and greater than three percent impairment of her left upper extremity. After this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision.

[27] *See W.W.*, Docket No. 18-0093 (issued October 9, 2018); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

[28] *See W.W., id.*; *Peter C. Belkind*, 56 ECAB 580 (2005); *Ayanle A. Hashi*, 56 ECAB 234 (2004).

ORDER

IT IS HEREBY ORDERED THAT the April 3, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this decision of the Board.

Issued: April 7, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board